PATIENT INFORMATION	PRESCRIBER INFORMATION
PATIENT NAME:	PRESBRIBER NAME:
DATE OF BIRTH: GENDER: M / F	SPECIALTY:
SSN:	ADDRESS:
ADDRESS:	
	PHONE:
PHONE:	FAX:
EMPLOYER:	DEA: NPI:

INSURANCE INFORMATION	DIAGNOSIS
INSURANCE PLAN NAME:	☐ E66.01 MORBID(SEVERE) OBESITY DUE TO EXCESS CALORIES
RX BIN: RX GROUP:	☐ E66.09 OBESITY DUE TO EXCESS CALORIES
ID:	☐ E66.3 OVERWEIGHT
MEDICARE ☐ MEDI-CAL ☐ COMMERCIAL ☐	☐ ICD 10_____DIAGNOSIS_____

MEDICATION	DIRECTIONS	QTY	REFILLS
☐ SAXENDA® (liraglutide [rDNA origin] injection)	☐ Week 1 Inject 0.6mg subcutaneously daily X 7 days Week 2 Inject 1.2mg subcutaneously daily X 7 days Week 3 Inject 1.8mg subcutaneously daily X 7 days Week 4 Inject 2.4mg subcutaneously daily X 7 days Week 5 Inject 3mg subcutaneously daily, thereafter	☐ 15mL	1 2 3 4 5
☐ NOVOFINE® 32G TIPS	☐ Use as directed with Saxenda Medication	☐ 1 Box	1 2 3 4 5

CLINICAL INFORMATION

1. CURRENT BMI: _____
CURRENT HEIGHT: _____
CURRENT WEIGHT: _____
2. GOAL WEIGHT: _____
3. CHECK THE PATIENTS CURRENT RISK FACTORS:

- ☐ **CORONARY HEART DISEASE**
- ☐ **DYSLIPIDEMIA**
- ☐ **HYPERTENSION**
- ☐ **SLEEP APNEA**
- ☐ **SNORING**
- ☐ **PRE-DIABETES**
- ☐ **TYPE II DIABETES**
  IS THE PATIENT ON INSULIN THERAPY?
  YES NO
- ☐ **JOINT PAIN**
- ☐ **DEPRESSION**
- ☐ **ELEVATED HEART RATE**

4. HAS THE PATIENT ATTEMPT TO LOSE WEIGHT IN A FORMALIZED WEIGHT MANAGEMENT PROGRAM FOR AT LEAST 6 MONTHS PRIOR TO USING DRUG THERAPY?

- ☐ **JENNY CRAIG®**
- ☐ **WEIGHT WATCHERS®**
- ☐ **NUTRISYSTEM®**
- ☐ **LINDORA®**
- ☐ **DIET AND EXERCISE**
- ☐ **OTHER:_____**

5. DOES THE PATIENT HAVE A PERSONAL OR FAMILY HISTORY OF MEDULLARY THYROID CARCINOMA? ☐ **YES** ☐ **N O**

6. HAS THE PATIENT BEEN DIAGNOSED WITH MULTIPLE ENDOCRINE NEOPLASIA SYNDROME TYPE 2? ☐ **YES** ☐ **N O**

7. SELECT MEDICATIONS THE PATIENT HAS A FAILURE, INTOLERANCE, CONTRAINDICATION:

☐ **BELVIQ®**	☐ **XENICAL®**	☐ **HYDROXYCUT®**
☐ **CONTRAVE®**	☐ **ALLI ®**	☐ **GREENT TEA EXTRACT®**
☐ **PHENTERMINE®**	☐ **QSYMIA®**	☐ **GARCINIA CAMBOGIA EXTRACT®**
☐ _____	☐ _____	
☐ _____	☐ _____	
☐ _____	☐ _____	

****PLEASE ATTACH COPY OF PRESCRIPTION, LABS, PROGRESS NOTES****

By signing below, the prescriber gives consent to **Orange Plaza Pharmacy to act as the prescriber's agent** to begin and execute the prior authorization process, as well as to help the patient apply to co-pay assistant programs (including coupons, foundations and manufacturer assistance programs if necessary). The prescriber certifies that the information is true, accurate and the requested services are medically necessary to the health of the patient.

PRECRIBER SIGNATURE: _____DATE:_____ ☐**DO NOT SUBSTITUTE**

****PLEASE CALL TO CONFIRM FORM WAS RECEIVED****

ORANGE PLAZA PHARMACY

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